Parenting in Dependency Drug Court

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ABSTRACT

The Dependency Drug Court (DDC) in Miami, Florida, addresses the needs of families affected by substance abuse through a comprehensive and therapeutic approach. The DDC works with community agencies to provide services that effectively treat the family as a unit. This article discusses the process of adapting a parenting program to meet the needs of families in the DDC.

Background

A vast majority of dependency court cases involve families affected by substance abuse (Office of National Drug Court Policy, 1998). These families have unique issues that are insufficiently addressed in a traditional court process in which the judicial norm is adult-centered and punitive with a criminal court theoretical framework. Drug courts have been established in many areas of the country to meet the needs of substance-abusing adults. These courts use a systematic approach that involves intensive monitoring. However, these adult-focused drug courts often do not attend to children's issues. Moreover, many dependency courts, while addressing issues involving maltreatment, have failed to address risk factors associated with substance abuse that affect the entire family unit.

Generally, the dependency court approach has not been successful with families in establishing permanency in an expedient manner for children; substance-abusing parents in traditional dependency courts have had a modest chance of regaining and maintaining custody of their children (McGee, Parnham, Morrigan, & Smith, 1998), and frequent relapses after a period of sobriety are common. Most important, children's needs are not being sufficiently addressed in dependency courts. Children in the dependency system, even if they are temporarily placed with relatives, face many problems affecting their developmental milestones due to separation from their parents (McGee et al., 1998).

In the early nineties in Miami-Dade County, there was a great discrepancy between the need for services for families affected by substance abuse and availability of these services. In particular, there existed infrequent supervision for substance-abusing parents completing case plans, including a lack of frequent drug testing and mandatory reporting from drug treatment providers about parental success in treatment programs (Montague, Hocutt, Fonseca, & Enders, 2000). In addition, the co-occurrence of substance abuse and mental health issues was ignored. Coordination of services among agencies was not well managed, in part due to

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lack of staff resources. In Miami-Dade County, the diversity of language, ethnic, and cultural backgrounds added to splintering the service provision. Information regarding case plan compliance was insufficient for judges to determine the best course of action for reunification and/or permanent placement. Follow-up and monitoring of needed services were inadequate. Caseworkers from Florida's Department of Children and Families reported that parents in the child welfare system with identified substance abuse problems were the most difficult and frustrating cases to manage. All these factors clearly pointed to an increased need for strong partnerships between child welfare, the court, and community service providers.

The Miami-Dade County, 11th Judicial Circuit Dependency Division of the Juvenile Court recognized the barriers evident to successfully addressing the needs of families with substance abuse issues through the traditional court process. Accordingly, an alternative approach was sought. The Miami-Dade Family Drug Court Initiative was funded through the Florida Legislature, with technical assistance monies supplied by the Center for Substance Abuse Treatment (CSAT). In 1999 and 2000, the Miami-Dade DDC served as a mentor court for CSAT.

Currently, Miami-Dade Dependency Drug Court (DDC) is an established family drug court in Miami. Since 1999, the Miami DDC has provided holistic and comprehensive therapeutic services for families affected by substance abuse. In its role as a CSAT-designated mentor court, the DDC has disseminated information and technical assistance and has provided support about the DDC program and its network of community professionals to juvenile dependency courts across the country. This article discusses the underlying approach and philosophy of this court and one parenting program that works in conjunction with it to provide services that support the family drug court philosophy.

Dependency Drug Court

The effects of substance abuse have been well documented in empirical and clinical studies. Much evidence shows that addiction affects not only the abuser, but also the entire family system (Chaffin, Kelleher, & Hollenberg, 1996; Murphy, Jellinek, Quinn, & Smith, 1991). Substance abuse is also highly likely to co-occur with other risk factors such as poverty, low educational levels, and mental health problems, as well as psychosocial issues (Beeghly & Tronick, 1994; Knight, Wallace, Joe, & Logan, 2001; Rounsaville et al., 1998; Smyth & Kost, 1998). These factors may precede, co-occur, or be the consequence of the addiction. Unless these factors are addressed simultaneously with substance abuse, they are likely to be barriers to recovery and rehabilitation. To improve the outcome for children and families, it is therefore necessary to provide a comprehensive approach that treats addiction in a family context and addresses all key risk factors associated with substance abuse (Brindis, Berkowitz, Clayson, & Lamb, 1997).

Communities vary in the quantity and quality of services, as well as in the efficiency of the service provision. As previously mentioned, in Miami-Dade County, there was a great discrepancy between the need for services and their availability, as well as a lack of coordination of services among agencies. The experience in dependency court is that multiple case workers are often assigned to a family but do not communicate efficiently with one another or the court. This splintering of services and lack of communication work to the detriment of families.

For a dependency court process to function efficiently and knowledgeably, judges require complete information about case plan compliance to make appropriate permanency decisions. For case plans to be relevant to family needs, the court must have information on extended family history, as well as information about the psychological and developmental status of the children. Follow-up and monitoring of needed services must be intensive.

Successful drug courts have bridged the gap between the court, treatment, and public health systems. These courts have taken a leadership role in coordinating services and communication among the various agencies involved in family welfare. Key components of a successful dependency drug court follow an interdisciplinary plan to heal families as a unit. Dependency drug courts facilitate enhanced communication among caseworkers, service providers, and the courts. These courts also institutionalize the referral of services, monitor case plans, and implement services to address the needs of children and families affected by substance abuse.

The Miami DDC addresses participant needs

through a comprehensive and therapeutic approach, including an intensive assessment of needs, case management, family services, and close monitoring. The DDC has necessitated a dramatic change in the judge's role. Not only does the dependency drug court judge monitor each case closely through frequent court visits, progress reports, and contact with the extended families, but the judge also monitors the system of service provision. Thus, the judge maintains close relationships with treatment providers and community agencies, thereby ensuring that the system of services continues to meet the needs of clients and positively impacts lifestyle changes for the family.

DDC caseworkers provide not only intensive case management, but also ongoing communication with professionals across several disciplines with which they are able to evaluate clients and provide appropriate services. Professionals outside the courts and the child welfare agency include early intervention specialists, substance abuse and mental health providers, trauma counselors, school specialists, nurse practitioners, and vocational rehabilitation counselors. Case management referrals may include substance abuse and mental health treatment, trauma and domestic violence counseling, family and couples therapy, parenting classes, educational/vocational training, housing, health/medical assessments, family planning, psychological and parenting capacity assessments, children's developmental, psychological, and educational assessments, and children's counseling and play therapy. The resulting case plans are extensive, holistic, and require a high degree of cooperation and commitment from the families. Thus, this court program is voluntary; families choose to submit to this process with advice from their legal counsel. Those who do not comply with requirements are terminated from drug court and are returned to the regular dependency court process.

Continual assessment of needs is vital to the DDC effectiveness. Each family has unique and specific needs that may change over time. These needs must be addressed in a systematic and timely fashion and be reassessed throughout the DDC process. Accordingly, a DDC "specialist" or caseworker, assigned to the DDC family, works with the child protective worker from the child welfare agency and professionals from other disciplines to provide case plan progress reports continuously throughout the program (Montague et al., 2000). These progress reports include reports on all treatment activities, including program attendance and progress gaining insight, AA/NA attendance, urine test results, visitation compliance, and recommendations for future action (Montague et al., 2000). The caseworker from the child welfare agency is primarily responsible for the safety and provision of services to the children, but the addiction specialist focuses on services for the parents. Both caseworkers work together to provide a comprehensive case plan. In addition, the DDC specialist provides a nurturing and therapeutic environment within which the parent can recover. Since DDC parents are primarily females, compassion for the trauma that the majority of them have experienced is essential (Montague et al., 2000).

Developing a Community Partnership for Parenting

The very fact that parents are involved in the DDC points to their inability to parent their children appropriately. Improving caregivers' parenting skills thus was recognized as an important component of healthy families. Mandating parenting classes was a common practice in dependency court, but no mechanism existed for ensuring that the classes were effective for families affected by substance abuse. In the past, providers of parenting classes were not required to employ empirically evaluated curricula or to be experienced in working with substance-abusing parents. Parenting classes varied greatly in content and expertise of facilitators. Attendance was typically used as the sole criterion for compliance with the program, and pre- and post-intervention data were rarely collected to determine insight and knowledge gained. Programs rarely provided an opportunity for parenting program facilitators to see the parents interact with their children or to determine whether parenting skills taught in the program were incorporated into family interactions. Accordingly, the DDC identified the need to collaborate with an agency that could provide an interactive, scientifically tested parenting component that could address the needs of families in the DDC and communicate in a meaningful way with the court.

The first step in the process was to select an agency that: was experienced in serving substance-abusing

families; had demonstrated a willingness to adopt the DDC philosophy of serving families; could assist in securing funding for the program; and was equipped to deliver an intervention sensitive to the specific population being served by the court. The agency selected was the Linda Ray Intervention Center (LRIC), a leader in Miami-Dade County in early childhood interventions since 1993. Based at the University of Miami, the LRIC provides services to families affected by substance abuse. The core program of the LRIC is a developmental intervention program for children prenatally exposed to cocaine. Additional programs include the Miami Safe Start Initiative and the Infant and Young Children's Mental Health Pilot Project. The primary intervention program is based on a public health model that emphasizes the effects of family and community systems on the development of children (Scott, Hollomon, Claussen, & Katz, 1998). While developmental interventions for children are the primary services delivered by the LRIC, a comprehensive array of services, including medical and social services are also provided.

Before the establishment of the DDC, the LRIC staff had increasingly appeared in court as child advocates who were often able to provide the court with detailed information about families. Over time, the LRIC's knowledge of family systems, its philosophy of comprehensive service provision, and its experience with families affected by substance abuse made the LRIC crucial to the court's understanding and monitoring of families. Additionally, it was apparent to the court that LRIC's provision of services was organized, accessible, and flexible, with sufficient staff and access to community services and the ability to assist in locating funding for parenting programs because of its connection with the University.

Selecting a Parenting Curriculum

The second step in providing a parenting component that could work for families in the DDC was to select a curriculum. To this end, the DDC-LRIC collaborative conducted a needs assessment of families affected by substance abuse, and the DDC clients specifically, to determine requirements for selecting an empirically based parenting program for this population. Parenting skills and caregiver-child relationships emerged as the main elements needed in a curriculum. The primary requirement for the parenting program was that it target at-risk populations and be adapted for use with substance-addicted parents. The characteristics and risk factors associated with families affected by substance abuse require specific attention and make it unlikely that such parents would succeed in a parenting program developed for normative, low-risk families.

The risk factors associated with substance abuse affect one's ability to parent in a variety of ways. Adults who abuse substances exhibit poor mental health, ineffective coping skills, and inadequate communication skills (The National Center on Addiction and Substance Abuse, 1999; Chaffin et al., 1996; Kumpfer, 1998; Murphy et al., 1991). These risk factors greatly compromise the parents' ability to provide a safe and nurturing home for children. Characteristics of families affected by substance abuse include lack of support and empathy, problematic and conflicted family relationships, negativity, stress, isolation, and lack of family cohesion and structure (Aseltine, Gore, & Colten, 1998; Costantini, Wermuth, Sorensen, & Lyons, 1992; Finkelstein, 1996; Johnson & Leff, 1999). All these factors can lead to later substance abuse for all family members (Aseltine et al., 1998; Costantini et al., 1992; Finkelstein, 1996; Johnson & Leff, 1999). Parents who use drugs tend to lack knowledge of child development, exhibit inappropriate expectations of their children, and demonstrate inadequate supervision and ineffective discipline skills (Burns, Chethik, Burns, & Clark, 1991; Kelley, 1992, 1998). Substance abuse in general is highly linked to child maltreatment (Chaffin et al., 1996; Kelley, 1992, 1998; Murphy et al., 1991).

Another requirement for the program was a focus on improving caregiver-child relationships. For this, both children and parents needed to learn direct skills and be given opportunities to examine their own values about their family. Topics of discussion needed to include issues of family conflict, stress management, cohesion building, and family support and structure (Finkelstein, 1996; Knight et al., 2001). Parents and children needed separate as well as joint opportunities to practice learned skills in a supportive environment.

To address issues specific to the Miami DDC population, the parenting program had to respond to several specific considerations. Miami-Dade County is highly diverse in culture, ethnicity, race, and language. The selected program would therefore need to provide a

cross-cultural approach. In addition, many adults in the DDC population lack educational and cognitive skills. Thus, the selected program had to be appropriate for individuals with low literacy and cognitive skills.

After determining the needs of the DDC population, the collaborative investigated evidence-based models of parenting curricula to determine which curriculum would be the most appropriate. After initial consideration of several programs, the collaborative decided to pilot the Strengthening Families (SF) family skills training model (Kumpfer, 1994). This intervention had been successfully implemented in independently evaluated clinical trials (Kumpfer, 1994) and matched the needs of the Miami DDC population. It was developed for at-risk populations and was adapted for use with substance-abusing parents. It included separate interventions for parents and children, with direct skills training and a joint intervention for the family as a unit. Most important, the intervention provided for hands-on practice of skills learned (Kumpfer, 1994). The protocol had been adapted and successfully used with multiethnic communities and was appropriate for individuals with low literacy and cognitive skills (Kumpfer, 1994).

The SF intervention is comprised of 14 weekly sessions that are divided into three-hour blocks. Each session consists of a family dinner, simultaneous but separate parent and child intervention sessions, and a family activity. The topics addressed in the adult group include child development, stress management, problem solving, communication, and discipline. When discussing discipline, the specific emphasis is interacting with children using rewards for good behavior, articulating goals, and setting limits. The topics addressed in the child intervention segment include developing social skills and good behavior, how to say no to stay out of trouble, communication, alcohol and drugs education, problem solving, feelings, and coping skills. The family activity provides an opportunity for participants to practice learned skills with modeling and guidance from facilitators.

Assessing Program Effectiveness

Strengthening Families was implemented at the LRIC as a pilot program in the first year of a two-year grant period beginning in 1999 with funding from the Center for Substance Abuse Treatment. In the second year, the collaborative evaluated the program's effectiveness through systematic qualitative observation and analysis by a process evaluator and through informal facilitator feedback. Although this curriculum was developed for families affected by substance abuse, it was determined that the SF approach did not sufficiently address the needs of the Miami DDC population. Despite the facilitators' experience in working with this population and their background in mental health counseling, fidelity to the program was difficult due to participant response. Adult participants seemed to resist the program content, displayed inappropriate behaviors during the sessions, and maintained few on-task behaviors. The didactic approach seemed to interfere with the building of trust among the group and to be ineffective with people with low literacy and cognitive skills. The deficit-based structure of the curriculum focused on convincing parents to make extreme changes in their behavior; none of the participants seemed ready to make those changes or convinced that they would work.

Participants were not open to discussing personal issues with the group and did not appear ready to change their behavior in the manner required for this approach. Two major factors may have contributed to their lack of disclosure. In order to provide feedback to the court on client progress, the case workers of several of the participants attended the meetings. The participants acted guarded and seemed reluctant to share personal information for fear of it getting back to the judge. In addition, the participants had not bonded with each other or the group facilitators and did not seem to trust the facilitators or value what they said.

Although participants did not typically disclose personal information, the information that was disclosed was highly emotional. The SF curriculum seemed to lack attention to the emotional issues expressed by the participants and did not address the participants' lack of empathy for others. Most substance-abusing parents are raised by substance abusers with poor parenting skills or are otherwise maltreated (Bennett & Kemper, 1994; Caudill, Hoffman, Hubbard, Flynn, & Luckey, 1994). The program did not address the intense negative emotional experiences in a parent's past that influenced the parent's ability to bond with and effectively parent his or her own children. Since the program was not values-

based, the parents engaged in the program from differing perspectives and with different life experiences. The lack of consensus among participants, as well as the lack of understanding regarding the familial cycle of poor parenting, led to resistance among participants and a chaotic environment.

The program coordinators decided, therefore, that review of an additional program that might address the above-stated needs was necessary. After careful consideration of programs and the needs identified, they selected the Nurturing Program for Families in Substance Abuse Treatment and Recovery (NPFSATR) (Finkelstein, 1996; Moore & Finkelstein, 2001). This program is an adaptation of the Nurturing Program (Bavolek, 1989), and has been successfully used with substance-abusing mothers (Camp & Finkelstein, 1997).

The focus of the NPFSATR program is on relationships and emotional issues. It specifically addresses parenting domains known to be associated with parental abuse or neglect. These domains include inappropriate expectations of children, lack of empathy toward children's needs, and belief in corporal punishment. The activities include experiential exercises such as games, craft projects, and role-play with parent-child role reversal. The program is specifically responsive to the literacy levels and learning styles of the DDC population. It also includes issues directly related to substance abuse and recovery. It focuses on group bonding and support and serves to decrease defensiveness and resistance to parenting classes.

Through the NPFSATR program, parents learn appropriate responses to their own need for nurturing and learn to establish appropriate models for their children. The program includes additional material to enhance parents' own ability to self-nurture through play, meditation, and self-expression in response to the high number of parents who experienced abuse and neglect in their own childhoods (Moore & Finkelstein, 2001, p. 225). The underlying philosophy of this program is focused on values and emotions and the parents' own childhood experiences as determinants of their parenting behavior. This approach allows parents, in the context of a nurturing environment, to understand themselves and their own developmental needs. Only after this is accomplished are the parents asked to apply that knowledge to an understanding of their children, thus enhancing parental empathy, a critical component of relationship-building skills. Promoting the nurturing aspects of the parent-child relationship reduces the risk of substance abuse for both parent and child, as well as intergenerational patterns of violence, abuse, and neglect (Moore & Finkelstein, 2001).

A drawback to the NPFSATR program is that it was designed for adults only and lacks the parent-child interactive component that both the court and the group facilitators deemed necessary to determine whether parenting strategies were being incorporated into the family's home environment. There was no intervention with the children in the NPFSATR to supplement the parents' learning of skills and no family activity to allow parents to practice newly learned skills. In addition, there was only limited content regarding specific parenting skills and behavior.

Because both the SF and the NPFSATR contained key elements that addressed the needs of this population, it was decided to use the NPFSATR to supplement the SF program rather than to replace it. The adult-only program would serve as a suitable prelude to implementing the Strengthening Families program, with the goal of establishing a nurturing and supportive environment among a bonded group, thereby facilitating more openness to the SF intervention.

By combining the two programs sequentially, participants would benefit from the strengths of both. Nonetheless, program adaptations needed to be made to meet DDC requirements. Families involved in the Miami DDC must complete their case plan within one year. Therefore, the NPFSATR program needed to be further modified with regard to length and content. According to the author of the NPFSATR curriculum, the number of sessions can be reduced from 18 to 12 without reducing efficacy. Accordingly, the collaboration decided to use both programs in sequence, beginning with 12 weeks of the NPFSATR program followed by 14 weeks of SF, for a combined 26 weeks of parenting intervention.

Once the programs were combined and implemented, systematic qualitative data through observation by a process evaluator, facilitator feedback, and client feedback were collected and analyzed. Overall, response to the program was more positive than previously found. Participants were more responsive and less resistant to the activities. A change in the group process and

a greater ease of facilitation were observed. Participants seemed to put more trust in the facilitators and were more willing to share emotions in the group. A sense of community atmosphere surrounded the meetings. Participants made friends within the group and were interested that other families had experienced similar problems. Use of both programs in sequence successfully addressed the individual programs' limitations.

Monitoring case plan progress is a crucial aspect of the DDC and its commitment to serving families. A method needed to be developed to allow appropriate communication and coordination between the parenting program and other DDC components. Specifically, case managers, addiction specialists, and the court needed to be informed about parents' progress. In addition, steady communication about participants needed to be in place to address barriers to attendance or additional needs and issues parents identified during the parenting classes.

An initial method of collaboration and communication with the DDC was to have case managers and addiction specialists attend parenting sessions. This method was discontinued, however, after the qualitative data showed that participants reacted negatively, viewing case managers as authority figures whom they resisted. The caseworkers' presence interfered with group bonding and parents' ability to disclose personal issues and weaknesses. It was decided, therefore, that feedback to the court would come from facilitators' progress reports. A key component for the feedback process was informal case review by the program director and the group facilitators. With participants' full consent, the amount and quality of participation were noted for each participant in the program. Additionally, progress notes included degree of change and resistance to change, the insight level of participants in meetings, and demonstrated skills learned while interacting with children. The director was in constant contact with the DDC specialists and case managers to assess participant progress. Finally, the director attended court hearings to report that progress to the judge. The court now had qualitative evidence on which to evaluate participants' increased insight into parent-child relationships.

Discussion

The national push toward the use of evidence-based parenting skills curriculums in court settings, including Family and Dependency Treatment Courts and Model Courts, has been evidenced in the work of the National Drug Court Institute (NDCI) and the National Association of Drug Court Professionals (NADCP), as well as within the Model Court movement. By assisting drug courts with their training and technical assistance needs, both NDCI and NADCP offer courts best practice information and illustrative community models of effective parenting skills curriculums.

It is essential for courts to understand the importance of cross-disciplinary partnerships in establishing a framework and infrastructure that support court operations. The Miami DDC has made this commitment to families and children. The DDC has provided a model approach to addressing risk factors associated with substance abuse in families and a model approach to collaboration with community stakeholders. By forming partnerships with service providers, the Miami DDC continues to systematize and institutionalize services available for families affected by substance abuse. Agencies collaborating with the DDC share similar philosophies about families affected by substance abuse. They recognize the importance of viewing the family as a unit and the need for multiple interventions for adults and children. The court understands the importance of cross-disciplinary partnerships to establish a framework and infrastructure to support court operations (McGee et al., 1998).

Community providers from Utah, California, Ohio, and North Carolina focus on dissemination of effective parenting skills models such as the Miami model in their drug courts. The Miami DDC and the Linda Ray Intervention Center have provided a model for other agencies in providing services to this special population. Drug court teams across the country visit the Miami DDC and the LRIC. Dialogues have continued across Model Courts, as well, regarding implementation of the Miami parenting skills model. The replication manual produced by the LRIC, outlining the parenting skills program, is often disseminated to both ongoing and newly funded court projects.

The DDC established a valuable collaborative with an intervention center that was most suited to deliver a needed intervention due to its match with the DDC's philosophy. Experience with the entire process of developing the collaboration, selecting, and then delivering

parenting intervention has allowed the DDC-LRIC collaborative to identify essential components necessary to delivering an effective intervention for families affected by substance abuse.

Any community agency chosen to work in a family or juvenile drug court environment must demonstrate the ability to provide a parenting program for families affected by substance abuse. The agency must show its knowledge of, and previous experience with, targeted families. The agency must be flexible with regard to scheduling the parenting program and must be accessible to families in the community. The chosen intervention must be selected to match the needs of the population served. A needs assessment through literature review and anecdotal data from service providers may help identify essential elements of a curriculum. Pilot programs may be helpful to make an initial assessment of participant response to the curriculum, but there is no substitute for implementing the program and assessing its effectiveness. Continual reassessment of program participants' needs provides formative feedback to allow for the continual adaptation of the interventions.

Once the agency and curriculum are selected, a determination should be made regarding appropriate staff. Careful consideration of requirements and training for facilitators and additional support staff is necessary. Experience with the Miami DDC population has illuminated the need for facilitators to have experience with, or training in, working with culturally and socio-economically diverse populations and with substance-abusing populations. Substance-abusing adults pose serious challenges to facilitating groups even when they are interested and open to the intervention. Training in mental health issues is very important because most co-occurring disorders are very prevalent in this population. Facilitators should also have experience and training in handling such behaviors as oppositional behavior, passive and active resistance, defensiveness, emotional sensitivity, apathy, a tendency to go off-topic, interruptions, inability to follow instructions, mood changes, and a tendency to give socially desirable answers. Co-facilitation is an important factor to consider when designing the local intervention. Qualitative data and facilitator feedback in the Miami program reflect that when facilitators took turns in leading group activities, enhanced participant attention and decreased fatigue for the facilitators resulted. A second facilitator also assisted in monitoring behavior and participation and could give individual attention to participants without interrupting the group process.

Additional support staff should also be considered when implementing an intervention. As participants feel more comfortable with the program and with the facilitators, they increasingly approach facilitators outside of planned activities to report on concerns in their lives, further discuss issues covered in class, or discuss issues triggered by some related topic. If facilitators are not available to provide additional support, then additional staff may be necessary. It is also important to have a sufficient number of experienced child caretakers because a significant proportion of the children have behavioral and emotional problems.

Finally, the program must develop a mechanism for monitoring parents' progress in the program and determining how much information should be disclosed to the court. Typically, parent groups function on the premise of confidentiality. However, in this program, disclosure may be necessary for appropriate feedback to the court. Parents must be clearly informed that information regarding their participation will be revealed to the court and that their progress will be documented. For example, attendance, participation, and facilitators' perception of progress are crucial pieces of importance for the court. Accordingly, issues of confidentiality must be addressed at the beginning of parenting sessions.

Continual assessment of needs and program effectiveness is essential to delivering an effective program that meets the needs of program participants. When obstacles to program success appear, interventionists need to be prepared to investigate issues and make a plan to respond to them. The collaborative program was able to collect and use qualitative data and facilitator feedback for this purpose. One or two process evaluators were needed to evaluate a group. Evaluation data included pre- and post-intervention questionnaires and interviews to determine the level of program impact and explore the process factors that impact program effectiveness. The program coordinator kept close contact with participants to work out issues of attendance and participation, including arranging transportation and child care. Finally, the evaluator worked closely with the program coordinator in adapting the program to

ensure optimum effectiveness.

It is essential to ensure that groups are of an appropriate size. Groups of 8-10 families are considered optimal for the program. The group size cannot be larger because in the Strengthening Families program parents and children are participating in group activities together, and adequate supervision and facilitator feedback are needed. With co-facilitation of both parent and child groups, four facilitators are available. Conversely, groups with fewer than five participants are also less optimal, because this may increase the likelihood for socially awkward interactions as the activities are designed for groups. With regard to group composition, qualitative data showed that in more culturally homogeneous groups, participants tend to be less open to change because group norms for parenting are already established by the culture. Homogeneous groups tend to perpetuate those parenting practices rather than encourage openness to learning new ones.

The DDC-LRIC collaborative currently provides knowledge to other courts and communities who serve the target population of substance-involved families. Through its program replication manual, the provision of continual training, and dissemination of information to local agencies and pivotal national organizations such as the National Drug Court Institute and the National Council of Juvenile and Family Court Judges, the DDC-LRIC collaborative continues to assist organizations in implementing a parenting program that is appropriate for substance-abusing parents and their children.

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REFERENCES

Aseltine, R. H. J., Gore, S., & Colten, M. E. (1998). The co-occurrence of depression and substance abuse in late adolescence. *Development and Psychopathology, 10*(3), 549-570.

Bavolek, S. J. (1989). Assessing and treating high-risk parenting attitudes. *Early Child Development and Care, 42,* 99-112.

Beeghly, M., & Tronick, E. Z. (1994). Effects of prenatal exposure to cocaine in early infancy: Toxic effects on the process of mutual regulation. *Infant Mental Health Journal, 15*(2), 158-175.

Bennett, E. M., & Kemper, K. J. (1994). Is abuse during childhood a risk factor for developing substance abuse problems as an adult? *Journal of Developmental and Behavioral Pediatrics, 15*(6), 426-429.

Brindis, C. D., Berkowitz, G., Clayson, Z., & Lamb, B. (1997). California's approach to perinatal substance abuse: Toward a model of comprehensive care. *Journal of Psychoactive Drugs, 29*(1), 113-122.

Burns, K. A., Chethik, L., Burns, W. J., & Clark, R. (1991). Dyadic disturbances in cocaine-abusing mothers and their infants. *Journal of Clinical Psychology, 47*(2), 316-319.

Camp, J. M., & Finkelstein, N. (1997). Parenting training for women in residential substance abuse treatment: Results of a demonstration project. *Journal of Substance Abuse Treatment, 14*(5), 411-422.

Caudill, B. D., Hoffman, J. A., Hubbard, R. L., Flynn, P. M., & Luckey, J. W. (1994). Parental history of substance abuse as a risk factor in predicting crack smokers' substance use, illegal activities, and psychiatric status. *American Journal of Drug and Alcohol Abuse, 20*(3), 341-354.

Chaffin, M., Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors from prospective community data. *Child Abuse and Neglect, 20*(3), 191-203.

Costantini, M. F., Wermuth, L., Sorensen, J. L., & Lyons, J. S. (1992). Family functioning as a predictor of progress in substance abuse treatment. *Journal of Substance Abuse Treatment, 9*(4), 331-335.

Finkelstein, N. (1996). Using the relational model as a context for treating pregnant and parenting chemically dependent women. In B. L. Underhill & D. G. Finnegan (Eds.), *Chemical dependency: Women at risk.* (pp. 23-44). New York: Harrington Park Press/Haworth Press, Inc.

Johnson, J. L., & Leff, M. (1999). Children of substance abusers: Overview of research findings. *Pediatrics, 103*(5, Pt 2), 1085-1099.

Kelley, S. J. (1992). Parenting stress and child maltreatment in drug-exposed children. *Child Abuse and Neglect, 16*(3), 317-328.

Kelley, S. J. (1998). Stress and coping behaviors of substance-abusing mothers. *Journal of the Society of Pediatric Nurses, 3*(3), 103-110.

Knight, D. K., Wallace, G. L., Joe, G. W., & Logan, S. M. (2001). Change in psychosocial functioning and social relations among women in residential substance abuse treatment. *Journal of Substance Abuse, 13*(4), 533-547.

Kumpfer, K. (1994). *Implementation manual for the Strengthening Families Program.* Salt Lake City: University of Utah Department of Health Sciences.

Kumpfer, K. L. (1998). Links between prevention and treatment for drug-abusing women and their children. In C. L. Wetherington & A. B. Roman (Eds.), *Drug addiction research and the health of women* (NIH Publication No. 98-4290 ed., pp. 13-32). Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health.

McGee, C. M., Parnham, J., Morrigan, T. T., & Smith, M. (1998). *Applying drug court concepts in the juvenile and family court environments: A primer for judges.* American University's Drug Court Clearinghouse and Technical Assistance Project, Drug Courts Program Office, Office of Justice Programs, U.S. Department of Justice.

Montague, M., Hocutt, A., Fonseca, F., & Enders, C. (2000). *Miami dependency drug court project evaluation.* Coconut Grove: Educational Research Services, Inc.

Moore, J., & Finkelstein, N. (2001). Parenting services for families affected by substance abuse. *Child Welfare, 80*(2), 221-238.

Murphy, J. M., Jellinek, M. S., Quinn, D., & Smith, G. (1991). Substance abuse and serious child mistreatment: Prevalence, risk, and outcome in a court sample. *Child Abuse and Neglect, 15*(3), 197-211.

The National Center on Addiction and Substance Abuse. (1999). *No safe haven: Children of substance-abusing parents* (Executive Summary). New York: Casa Columbia.

Office of National Drug Control Policy. (1998). *Looking at a decade of drug courts.* Unpublished manuscript, Washington, DC.

Rounsaville, B. J., Kranzler, H. R., Ball, S., Tennen, H., Poling, J., & Triffleman, E. (1998). Personality disorders in substance abusers: Relation to substance use. *Journal of Nervous and Mental Disorders, 186*(2), 87-95.

Scott, K. G., Hollomon, H., Claussen, A. H., & Katz, L. (1998). Conceptualizing early intervention from a public health perspective. *Infants and Young Children, 11*, 37-48.

Smyth, N. J., & Kost, K. A. (1998). Exploring the nature of the relationship between poverty and substance abuse: Knowns and unknowns. *Journal of Human Behavior in the Social Environment, 1*(1), 67-82.